INTERIM COMMITTEE ON INDIGENT HEALTH CARE

FINAL INTERIM REPORT

January, 1987

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INTRODUCTION

The Missouri House of Representatives' interim committee on indigent health care was appointed by Speaker of the House Bob F. Griffin to accomplish two objectives. First, the committee was to study the effect of uncompensated health care costs on Missouri's health care delivery system. Second, it was to analyze policy options to reduce the adverse effects of uncompensated health care and develop appropriate legislative proposals.

The committee used as a starting point for its deliberations the "Missouri Indigent Health Care Study." The General Assembly, recognizing the need for specific information regarding the extent to which Missourians are unable to pay for health care, appropriated funds in 1985 for a comprehensive study of the problem. The study was conducted by Health Systems Research, Inc., a consulting firm specializing in health care finance policy.

The study speaks for itself. We will not delve into the details of the three hundred fifty page document other than to recite its conclusion that 1,000,000 Missourians, 20% of the state's population, have either no health insurance or substandard insurance coverage. 617,000 were found to have no health insurance coverage at least once during a year, 300,000 low-income, nonelderly persons to have inadequate private insurance, 55,000 low-income elderly persons to lack necessary Medicare supplement insurance, and 36,000 people, regardless of income, to incur annual medical expenses in excess of ten percent of their household income.

In its hearings around the state, the committee sought to determine if the numerical findings of the study were validated by testimony from those familiar with the issue -- health care providers, consumers, Medicaid recipients, victims of catastrophic illnesses, social service advocacy groups, businesses concerned with the cost of health care insurance, state agency representatives, etc. Many witnesses spoke directly to the findings of the study. Others confirmed its conclusions with anecdotal evidence.

The committee also sought and received testimony as to the implications of the report for state policy. Witnesses made various legislative proposals and discussed bills previously considered by the General Assembly.

CAUSES OF THE INDIGENT CARE PROBLEM

Historically, much of the cost of uncompensated health care has been dealt with by providers increasing charges to paying customers to cover the cost of such care. This process is known as cost-shifting. Also, many hospitals participated in the Hill-Burton program, a postwar federal program which required hospitals receiving federal subsidies for capital expansion to provide a certain amount of charity care.

The question arises, then, as to why those mechanisms are becoming less viable. Why has uncompensated care become an increasingly pressing problem in recent years? Most of the important reasons can be categorized under two responses -- an increasing lack of adequate health insurance coverage and changes in the health care marketplace.

I. An increasing lack of adequate insurance coverage

Changing employment patterns. Health insurance is most commonly provided as a fringe benefit of employment. However, the U.S. economy is changing from an emphasis on manufacturing and production to service sector jobs. As manufacturing jobs disappear, displaced workers are finding new jobs which do not provide health insurance, jobs such as fast-food workers or discount store clerks. Many such jobs do not pay well enough to allow the purchase of individual health coverage policies.

A poor agricultural economy. Falling prices for agricultural products and plummeting land values have caused depressed economic conditions across much of rural Missouri. As farms falter so do economic conditions in rural towns, leaving many without jobs or sufficient income to buy private health insurance coverage.

Costly medical treatment capabilities. Medical practitioners are constantly improving their ability to save patients with conditions that would have been fatal 40 or 50 years ago. Unfortunately, advanced medical technology is expensive, beyond the reach of all but the wealthiest individuals unless health insurance coverage is available. The uninsured are faced with a choice between not receiving care and accepting charity care, a dilemma voiced by several witnesses before the committee.

Ineligibility for coverage. Patients with serious ailments often find that health insurance becomes unavailable or prohibitively expensive. Without adequate coverage, even minor health care can be a heavy financial burden. As health care costs have risen rapidly during the past several decades, health insurance has become a necessity.

Restricted governmental expenditures for health care. During the last decade, reimbursements for Medicare and Medicaid patients have been limited or reduced to control expenditures. As health care costs have risen, reimbursements have not kept pace. The difference between costs and reimbursements is known as contractual allowances.

Governmental funding for public and teaching hospitals, an important component of health care for the indigent, is also being reduced or limited in growth because of restrained governmental spending.

II. Changing Health Care Marketplace

As various changes in the health care marketplace limit the ability of health care providers to pass on the costs of uncompensated care, the impact of such care upon their financial solvency increases.

Changes in governmental reimbursement procedures. In recent years, both Medicare and Medicaid have been altered so as to minimize cost-shifting to the patients they insure. Both programs now reimburse based not on retrospective charges but prospective average costs for a particular diagnosis. As a significant number of patients have health insurance through Medicare or Medicaid, these restrictions on cost-shifting force health care providers to shift costs to a smaller number of patients or to absorb those costs.

Health discounts for employers. Employers, like governments, have become increasingly sensitive to expenditures for health care made on behalf of their employees. The increased use of health insurance arrangements such as health maintenance organizations and preferred provider agreements has allowed businesses to limit the amount of cost-shifting to the patients they insure. As the health care marketplace grows more competitive among providers, the use of capitated payment systems such as HMO's and PPA's will become more common, further restricting the number of patients to whom health care providers can shift costs.

Liability insurance increases. Liability insurance premiums for health care providers have increased dramatically during the latest medical malpractice insurance "crisis." This increase has caused the cost of providing health care to each patient to rise. Thus, providing care to indigent patients is more costly to providers than in the past.

The use of Medicaid to fund long term care. The Medicaid program is increasingly used to fund payments for long-term custodial nursing home care for the indigent elderly. The percentage of Medicaid expenditures used for nursing home care is high and likely to increase as the population ages. The use of Medicaid as a payment source for long-term care benefits the indigent

elderly, but reduces Medicaid resources for noninstitutionalized patients and the providers who treat them.

Expiration of Hill-Burton obligations. As mentioned previously, hospitals which took advantage of a postwar federal program to subsidize hospital expansion are required to provide a certain amount of charity care to indigent patients. However, a hospital accepting funds need only provide obligatory charity care for twenty years after the capital expansion is completed. These Hill-Burton obligations are now expiring for many hospitals and all will have expired by 1994.

SOLUTIONS

I. Premises

The committee bases its findings and recommendations on two premises. The first is that health care for those not covered by private or governmental insurance is an express social responsibility. Historically, health care for the uninsured has been addressed largely by health care providers raising rates for paying customers to cover the cost of such uncompensated care. The cost, therefore, has been paid by those purchasing health care and the insurance plans which covered them. This cost is passed on to consumers through higher insurance premiums paid by both purchasers of individual policies and employer group plans. Increased costs to employers are passed on to consumers through higher product prices.

This system of access and payment is becoming less viable with the competitive marketplace restricting the ability to cost-shift. It is also less preferable in that the social expenditures for such care are not expressly recognized or managed. They take the form of hidden "indirect costs."

These costs should be formalized, monitored, and controlled as express social costs. Hence, some type of governmental management is necessary to ensure that access to health care is fair and based on uniform criteria and that the cost of such care is managed efficiently and explicitly.

The second premise of the committee is that limited legislative proposals should only be enacted in conjunction with a comprehensive plan to provide insurance to all who need it. A variety of proposals have been advanced in response to current problems with uncompensated care. Each of these proposals would doubtless be effective in addressing a portion of the problem. For example, the Health Systems Research report makes a number of recommendations, including the establishment of "medically needy" program to cover persons not currently eligible for Medicaid. A medically needy program would provide Medicaid coverage for pregnant women, children, and certain groups of aged or disabled persons.

The enactment of piecemeal solutions would expand coverage for certain groups or make certain programs more efficient, but would not provide a solution comprehensive enough to benefit the 1,000,000 Missourians identified by the report to be in need of assistance. The individual recommendations should be implemented only within the context of an overall plan to ensure adequate insurance coverage for all those in need.

II. Recommendations

Recommendation 1: The General Assembly should adopt legislation to establish a state "MedAssist" trust fund to provide health insurance for those unable to qualify for existing governmental health insurance programs or to acquire adequate private health insurance coverage. Funding should be selected by the General Assembly from one or a combination of the following revenue sources: increases in the income, sales, cigarette, or insurance premium taxes; assessments on health care providers or employers; or earmarking of a portion of the projected tax revenue "windfall" caused by federal income tax revisions. The funding source should be earmarked and subject to referendum.

20% of the state's population lacks adequate health insurance or has substandard coverage, according to the Health Systems Research report. The state must provide these Missourians with access to adequate health insurance based on their ability to pay.

Various states have considered legislative proposals to help the uninsured. Hawaii, armed with a federal waiver which allows it to regulate self-insured groups, mandates that all employers offer health insurance coverage. One state has considered providing uninsured persons with vouchers for the purchase of approved private insurance policies. Missouri has also considered a proposal to make health insurance available to the uninsured -- House Bill 1337 of the 1986 legislative session.

The committee supports some of the provisions of HB 1337, as follows:

1. Health insurance should be made available to those without adequate health insurance through a program funded by new revenues and by premiums based on ability to pay. A "MedAssist" program similar in scope to that proposed in HB 1337 could not be supported by existing revenues without crippling other essential state services.

2. Coverage should be extended to the groups identified in the Health Systems Research report: those not covered by governmental insurance programs who cannot afford adequate health insurance, experiencing a catastrophic illness which prevents them from acquiring insurance coverage, and senior citizens covered by Medicare who cannot afford necessary Medicare supplement insurance.

3. The program should be administered in keeping with accepted actuarial principles and procedures of private insurance companies. The program should be reviewed regularly by an independent health actuary to ensure fiscal soundness.

4. A program should be administered to include mandatory health care cost containment controls. Utilization review, preadmission review, second surgical opinions,and similar cost containment measures are being implemented in both governmental and private insurance programs. MedAssist administrators should use the procedures to ensure that payment is made only for health care which is necessary and efficient.

Any such legislative proposal to establish a MedAssist program should emphasize efficiency and public accountability by meeting the following conditions:

Accountability

1. The General Assembly should maintain authority over fiscal and regulatory administration of the program through its appropriation and regulatory review powers.

2. Program benefits provided to recipients must be defined so as not to exceed revenues. The state should not create an open-ended entitlement program; there must be a fixed cap on the revenue dedicated to a MedAssist program. Allowing program administrators to adjust benefits to conform with available revenue would give them the flexibility to tailor the best benefit plan without requiring statutory revision.

3. Proposed legislation should contain a sunset clause to mandate that a MedAssist program be discontinued unless reapproved by the General Assembly or, ideally, by referendum.

Efficiency

1. A MedAssist program should be administered by a board of directors rather than by a state agency. The board should be experienced in the development and management of insurance plans. Operating within statutory constraints, a board of directors make full use of its membership's experience in insurance, health care, and health care cost containment.

2. Claims processing for MedAssist benefits should be performed by a private company selected by competitive bid. This would minimize the need for governmental bureaucracy and capital facilities.

Recommendation 2: The General Assembly should consider expansion of Medicaid eligibility to maximize the use of federal funding.

In addressing the indigent care problem, the state should maximize its use of available federal funding. One means of doing this is to expand Medicaid eligibility to cover those who would otherwise be covered by a state-funded MedAssist program.

As sixty percent of Medicaid expenditures are paid by the federal government, state funds would be conserved. The federal government allows Medicaid coverage to be extended to certain groups such as pregnant women and children under the "medically needy" program. In addition, the MedAssist and Medicaid programs should be coordinated to ensure that care for those eligible for Medicaid coverage is not paid by the MedAssist program.

In developing a state insurance program to complement coverage through existing governmental programs such as Medicaid, the General Assembly should take precautions to prevent the development of a "three-tiered" health care system, with the best quality health care reserved for those with private or employer insurance, more restricted and inaccessible care for those covered by a state insurance plan as suggested here, and the most constrained and inaccessible care provided to Medicaid recipients.

Recommendation 3: The General Assembly should enact legislation authorizing a county-option sales tax to be used to fund local indigent care programs.

Should a MedAssist plan be rejected by either by the General Assembly or by referendum, local governments should be given the authority to submit proposals to county voters to fund local solutions.

Recommendation 4: The General Assembly should allow physicians providing care through local public health centers to participate in the state's Legal Expense Fund.

Skyrocketing medical malpractice premiums have reduced the availability of health care to the indigent or uninsured. For example, payments for obstetrical care and deliveries for Medicaid patients do not even cover the cost of the typical physician's liability cost for such care. Some physicians have stopped treating Medicaid patients, performing obstetrical services, or seeing patients in local public health clinics.

Allowing physicians to receive a partial reduction of liability for care provided in a public health center would increase the availability of care. Their participation in the State Legal Expense Fund would allow them to benefit from the same caps on liability as are provided state physicians when providing services on behalf of the state.

Recommendation 5: The General Assembly should adopt legislation to provide an insurance pool to provide coverage for those unable to qualify for insurance coverage.

If not incorporated as a part of a MedAssist program, the General Assembly should enact legislation to ensure that those who cannot qualify for private health insurance regardless of

their ability to pay are provided with access to insurance through an insurance risk pool.

Recommendation 6: The General Assembly should scrutinize eligibility criteria and benefits of existing programs which provide health care services to the uninsured or indigent to ensure administrative efficiency.

The "Missouri Indigent Health Care Study" by Health Systems Research, Inc. identifies and discusses programs which provide health care exclusively or partly to low-income persons. The information warrants attention. For example, the study describes the state's various programs to provide prenatal and perinatal care to low-income women. Differences in eligibility standards, benefit levels, and reimbursement procedures are sometimes striking. The General Assembly and the executive branch should work closely and diligently to ensure that programs are not duplicative and provide benefits equitably.

SCHEDULE OF COMMITTEE ACTIVITIES

The committee held the following hearings:

August 12-13	Capitol Building Jefferson City
September 16	Red Cross Building St. Louis
	St. Mary's Health Center St. Charles
October 1	Truman Medical Center Kansas City
October 2	Missouri Western State College St. Joseph
October 21	Jenny Lind Hall Springfield
November 12	Capitol Building Jefferson City
December 11	Capitol Building Jefferson City

WITNESSES

Hospitals

Truman Medical Center, Kansas City
St. Joseph's Health Center, St. Charles
Cox Medical Center, Springfield
St. Louis Regional Hospital, St. Louis
University Health Services, Kansas City
St. Mary's Health Center, Kansas City
Children's Mercy Hospital, Kansas City
Heartland Health System, St. Joseph
Cameron Community Hospital, Cameron
Bethany Medical Center, Mexico
St. Peters Hospital, St. Charles
Wentzville Hospital, Wentzville
Missouri Hospital Association
St. Mary's Hospital, Jefferson City
St. John's Hospital, Springfield

Physicians

Family practitioner, Mound City
Retired M.D., St. Louis
Pediatrician, St. Charles
Neonatologist, Springfield
(2) Family practitioners, Springfield
(2) Obstetricians, Springfield

Nurses

Missouri Nurses Association
(2) School Nurses

Home Health

Missouri Visiting Nurses Association
Home health agency

Local Governments/Public Health Depts.

Kansas City Dept. of Health
Prenatal Clinic, Buchanan County Public Health Dept.
Buchanan County Public Administrator
Greene County Public Health Dept.
Mid-America Regional Council

State Agencies and Representatives

Dept. of Mental Health
Division of Medical Services/Dept. of Social Services
Division of Family Services/Dept. of Social Services
Dept. of Health
Division of Insurance/Dept. of Economic Development
State representative

Social Service/Social Service Advocacy

Missouri Association for Social Welfare
Mid-America Assistance Coalition
Gray Panthers
Women's Equity Action League
Family Planning Services
Head Injury Foundation
Buchanan County Welfare Board
Communicating for Agriculture, Inc.
Lutheran Family and Children's Services
Diabetes Association
Missouri Protection and Advocacy Services
Salvation Army
People's Coalition of Missouri
Springfield Council of Churches
American Association of Retired Persons
Reform Organization of Welfare
Medicaid Alliance

Consumers

7 consumers had problems in paying for pregnancy care
6 consumers had problems concerning coverage of or after catastrophic illness
2 consumers were Medicaid recipients
4 consumers had no insurance coverage following unemployment

Businesses or Business Coalitions

Mid-America Coalition on Health
St. Louis Area Business/Health Coalition
General American Life Insurance Company
McDonnell Douglas

Labor Groups

AFL-CIO United Way Service, St. Joseph

SUMMARY OF TESTIMONY

The committee held many hours of hearings. All of the suggestions made cannot be expressed here. The following information provides an overview of some of the opinions expressed to the committee.

Hospitals

* Changing governmental and private insurance reimbursement systems are exacerbating the indigent care problem.

* Medicaid reimbursements are often inadequate to cover the costs of treatment.

* Prenatal care and preventative care are cost-efficient.

* Increased uncompensated care will force some hospitals to limit indigent care in order to remain fiscally solvent.

* Hospitals' indigent care burdens have increased significantly in recent years.

* Governmental regulations have increased the cost of hospital care.

* Many rural hospitals are in danger of closing.

* Patients are delaying needed treatment because of inability to pay.

* Public and children's hospitals are bearing a disproportionate share of the indigent care burden because of their missions and clientele.

Physicians

* Economic conditions in rural areas are seriously affecting patient's willingness to seek needed care and their ability to pay for it.

* Physician recruitment and retention is difficult in depressed rural areas.

* Increasing costs of liability insurance are adversely affecting physicians' ability to provide charity care.

* Prenatal care is cost-efficient.

* The liability exposure of physicians for indigent care should be reduced.

* The state should set up programs to reduce the cost of caring for "walk-in" obstetrical patients, especially in Springfield.

Nurses

* School nurses are seeing increasing needs for adequate health care in children of families who cannot afford care for all their members.

* Nurses should be specifically included into a MedAssist program, as they are cost-effective health care providers.

* Preventative health care should be emphasized.

* The expanded role of nursing should be used to improve access to health care.

Home Health

* Home health care is cost-effective and should be specifically encouraged in state medical assistance programs for the indigent.

Local Governments/Public Health Departments

* Reimbursements for health care through capitated state programs are increasingly inadequate.

* A state indigent care program would improve the availability of needed preventative and primary care.

* Physicians providing services in public health clinics should have less paperwork and less liability exposure.

* Local governments are adversely affected by rural economic problems and have limited ability to address increased indigent care problems.

* The establishment of a medical residency program in Springfield would improve care there.

State Agencies and Representatives

* A study of indigent health care in Missouri by Health Systems Research, Inc. found that 20% of the state's population has substandard health insurance coverage.

* The state's institutionalized mental health patients usually have no health insurance coverage and, if not covered by Medicaid, their care is usually paid solely by the state.

* Insurance coverage for mental health would benefit the state.

* A state grant proposal to a private foundation may improve access to indigent care services.

* Preventative care should be emphasized by the state.

* In addressing the indigent care problem, the state should avoid a premium tax or mandated benefits.

* In developing a MedAssist program, procedures should be coordinated with the Medicaid program to maximize federal funding.

* The Medicaid program is designed only to provide care for certain categories of recipients, not for all those below income guidelines.

* A medically needy program should be enacted as part of Medicaid.

* Counties need the authority to levy taxes for indigent care.

* A referendum election for the MedAssist program would be costly; funding from sales tax is regressive and should be avoided.

Social Service Advocacy

* The Medicaid program does not provide acceptable health care because of poor reimbursements for services and cost-containment policies which restrict access to the most effective care.

* Eligibility limits for Medicaid are too low to provide coverage for those who need health care and cannot afford it.

* High-risk insurance pools are effective means of ensuring access to coverage.

* Even modest deductibles and copayment rates will deter impoverished patients from getting care.

* Primary health care should be encouraged.

* Sales tax should be exempted from insulin and diabetic syringes.

* The state should have an open formulary for pharmaceuticals.

* The disabled and handicapped have difficulty getting insurance.

* Health programs should concentrate on patients' most essential needs and should emphasize preventative care.

* The state should ensure that insurance "continuation and conversion" policies are available.

* Family planning programs are cost-effective.

* Long-term care should be part of the coverage of a MedAssist program.

* MedAssist benefits should not be better than Medicaid benefits.

* Current income maintenance policies are a disincentive to work.

* Psychiatric illnesses should be covered on a par with physical ailments.

Consumers

* The costs of a catastrophic illness can cripple a family of moderate income with normal insurance coverage.

* Respite care is needed for the families of patients with catastrophic illnesses.

* Insurance for high-risk patients is unaffordable or unavailable.

* Freedom of choice among physicians should be part of governmental health programs.

* Medicaid limits on certain services adversely affect health.

* Patients who cannot afford care forego needed services.

* Patients who cannot afford care are generally willing to pay reasonable amounts for insurance coverage.

* Minimum wage workers cannot afford insurance if it is not offered as a fringe benefit of employment.

* Temporary unemployment causes temporary but risky medical indigence.

Business or Business Coalitions

* The benefit plan of a MedAssist program should be designed so as not to exceed available revenues.

* Competition in the health care system should be encouraged.

* A MedAssist program should be enacted for several years rather than permanently to allow for program review.

* Indigent patients should be expected to pay for a portion of their care.

* The Medicaid program should not be expanded.

* A MedAssist program should be based on actuarial principles.

* An indigent care program should use utilization review, avoid mandated benefits, distribute costs fairly, and maximize federal funding.

* Health care providers should stop cost-shifting if a state program is implemented.

Labor Groups

* The poor agricultural economy is harming patients' ability to pay for and willingness to receive needed care.

* The economy is increasingly emphasizing jobs which are low-paying and do not have insurance benefits.

* Increased sales tax should not be used to fund a MedAssist program, for it is regressive. The income tax should be used instead.

* The MedAssist program should benefit rural as well as urban areas.